MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Jack A Sloane, DC PO Box 1404 Decatur TX 75234-6145	MDR Tracking No.: M4-04-2296-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 47 Continental Casualty Co. / Burns Anderson Jury & B. PO Box 26300 Austin TX 78755-0300	Date of Injury: Employer's Name: R M Crowe Holding, LP Insurance Carrier's No.: 64689054

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/21/02	**10/21/02**	**97032(x2)**	**$44.00**	**$44.00**

PART III: REQUESTOR'S POSITION SUMMARY

10/13/03: Request for MDR. There has been a denial on a date of service that is not consistent with TWCC guidelines…we ask for your assistance in resolving the medical dispute. 10/13/03: TO: TWCC, Compliance & Practices…we never received a response from out request for reconsideration."

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not submit a statement with response to the TWCC 60 form.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT code 97032(x2): DOS 10/21/02 was denied as follows: 'F – Fee Guideline MAR Reduction, reimbursement has been calculated according to state fee schedule guidelines.'

- Documentation supported services as billed. According to the Medical Fee Guideline, Medicine Ground Rule, (I)(A)(10)(a), additional reimbursement recommended, $44.00.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
10/21/2002	97032 x 2	$44.00	$44.00				
				Total Left Column:			$44.00
				Total Amount Due:			$44.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $_____. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Carol Lawrence	03/18/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____